FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0005439

Facility Name: METHODIST HOME

Address: 1415 W. FOSTER AVENUE (Number) CHICAGO (City) 60640 (Zip Code)

County: COOK

Telephone Number: (773) 769-5500 **Fax #** (773) 769-6287

IDPA ID Number: 36-2210011001

Date of Initial License for Current Owners: UNKNOWN

Type of Ownership:

[X] VOLUNTARY,NON-PROFIT		[ ] PROPRIETARY		[ ] GOVERNMENTAL	
	[X] Charitable Corp.		[ ] Individual		[ ] State
	[ ] Trust		[ ] Partnership		[ ] County
IRS Exemption Code 501c3			[ ] Corporation		[ ] Other
			[ ] "Sub-S" Corp.		
			[ ] Limited Liability Co.		
			[ ] Trust		
			[ ] Other		

In the event there are further questions about this report, please contact:
Name: Jim Zoros, Controller **Telephone Number:** (773) 769-5500

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ 03/15/01 (Date)

(Type or Print Name) William A. Lowe

(Title) Chief Operating Officer

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number METHODIST HOME # 0005439 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	23	Skilled (SNF)	23	8,418	1
2		Skilled Pediatric (SNF/PED)			2
3	86	Intermediate (ICF)	86	31,476	3
4		Intermediate/DD			4
5	22	Sheltered Care (SC)	22	8,052	5
6		ICF/DD 16 or Less			6
7	131	TOTALS	131	47,946	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,383	2,567	2,089	7,039	8
9	SNF/PED					9
10	ICF	15,155	14,064		29,219	10
11	ICF/DD					11
12	SC		5,703		5,703	12
13	DD 16 OR LESS					13
14	TOTALS	17,538	22,334	2,089	41,961	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.52%

D. How many bed-hold days during this year were paid by Public Aid?
124 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Clinic - Community Health Care

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 1898

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 23 and days of care provided 2,072

Medicare Intermediary AdminaStar

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number METHODIST HOME # 0005439 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	247,416	22,440	107,668	377,524		377,524		377,524			1
2	Food Purchase		248,320		248,320		248,320	(7,518)	240,802			2
3	Housekeeping	147,558	27,966		175,524		175,524	(7,200)	168,324			3
4	Laundry	31,533	17,472		49,005		49,005		49,005			4
5	Heat and Other Utilities			133,380	133,380		133,380		133,380			5
6	Maintenance	120,213	29,523	66,859	216,595		216,595	(6,360)	210,235			6
7	Other (specify):*											7
8	**TOTAL General Services**	546,720	345,721	307,907	1,200,348		1,200,348	(21,078)	1,179,270			8
	B. Health Care and Programs											
9	Medical Director			37,799	37,799		37,799		37,799			9
10	Nursing and Medical Records	1,636,860	129,324	32,531	1,798,715		1,798,715		1,798,715			10
10a	Therapy			9,945	9,945		9,945		9,945			10a
11	Activities	93,182	9,562	13,353	116,097		116,097		116,097			11
12	Social Services	83,536	1,890	3,338	88,764		88,764		88,764			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,813,578	140,776	96,966	2,051,320		2,051,320		2,051,320			16
	C. General Administration											
17	Administrative	81,406			81,406		81,406		81,406			17
18	Directors Fees											18
19	Professional Services			51,359	51,359		51,359		51,359			19
20	Dues, Fees, Subscriptions & Promotions			113,234	113,234		113,234	(21,271)	91,963			20
21	Clerical & General Office Expenses	310,937	36,751	91,407	439,095		439,095	(55,031)	384,064			21
22	Employee Benefits & Payroll Taxes			463,914	463,914		463,914		463,914			22
23	Inservice Training & Education			381	381		381		381			23
24	Travel and Seminar			18,922	18,922		18,922		18,922			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			43,264	43,264		43,264		43,264			26
27	Other (specify):*											27
28	**TOTAL General Administration**	392,343	36,751	782,481	1,211,575		1,211,575	(76,302)	1,135,273			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,752,641	523,248	1,187,354	4,463,243		4,463,243	(97,380)	4,365,863			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number METHODIST HOME #0005439 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			281,979	281,979		281,979	(11,673)	270,306			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			82,290	82,290		82,290	(6,103)	76,187			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			13,301	13,301		13,301		13,301			35
36	Other (specify):*											36
37	**TOTAL Ownership**			377,570	377,570		377,570	(17,776)	359,794			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		228,994	144,215	373,209		373,209		373,209			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			59,842	59,842		59,842		59,842			42
43	Other (specify):* **Marketing**	25,498			25,498		25,498	(25,498)				43
44	**TOTAL Special Cost Centers**	25,498	228,994	204,057	458,549		458,549	(25,498)	433,051			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,778,139	752,242	1,768,981	5,299,362		5,299,362	(140,654)	5,158,708			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number METHODIST HOME # 0005439 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(7,518)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,925)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(11,673)	30		9
10	Interest and Other Investment Income	(6,103)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(30,198)	21		24
25	Fund Raising, Advertising and Promotional	(8,147)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(13,124)	20		28
29	Other-Attach Schedule	(55,966)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (140,654)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (140,654)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

METHODIST HOME

ID# 0005439

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Winwood Revenue - Maintenance	$ (6,360)	6	1
2	Winwood Revenue - Housekeeping	(7,200)	3	2
3	Winwood Revenue - Management	(13,764)	21	3
4	Miscellaneous Income	(3,144)	21	4
5	Marketing	(25,498)	43	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
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72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(55,966)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number METHODIST HOME # 0005439 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(7,518)	0	0	0	0	0	0	0	0	0	0	(7,518)	2
3	Housekeeping	(7,200)	0	0	0	0	0	0	0	0	0	0	(7,200)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(6,360)	0	0	0	0	0	0	0	0	0	0	(6,360)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(21,078)	0	0	0	0	0	0	0	0	0	0	(21,078)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(21,271)	0	0	0	0	0	0	0	0	0	0	(21,271)	20
21	Clerical & General Office Expenses	(55,031)	0	0	0	0	0	0	0	0	0	0	(55,031)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(76,302)	0	0	0	0	0	0	0	0	0	0	(76,302)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(97,380)	0	0	0	0	0	0	0	0	0	0	(97,380)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number METHODIST HOME # 0005439 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(11,673)	0	0	0	0	0	0	0	0	0	0	(11,673)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,103)	0	0	0	0	0	0	0	0	0	0	(6,103)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(17,776)	0	0	0	0	0	0	0	0	0	0	(17,776)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(25,498)	0	0	0	0	0	0	0	0	0	0	(25,498)	43
44	**TOTAL Special Cost Centers**	(25,498)	0	0	0	0	0	0	0	0	0	0	(25,498)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(140,654)	0	0	0	0	0	0	0	0	0	0	(140,654)	45

Facility Name & ID Number METHODIST HOME # 0005439 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
UNITED METHODIST HOMES & SERVICI	100 %			NAPER VALLEY CO	CHICAGO	INACTIVE
				UMH&S FOUNDATI	CHICAGO	FOUNDATION
				WINWOOD APARTM	CHICAGO	ELDERLY HOUSI

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number METHODIST HOME # 0005439 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number METHODIST HOME # 0005439 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number METHODIST HOME # 0005439 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Bonds		X	Refinance Buildings & Renovations		07/20/98	$ 1,225,761	$ 1,225,761	07/20/23	4.1-5.5%	$ 82,290	1
2												2
3												3
4												4
5									Interest Income Offset		(6,103)	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 1,225,761	$ 1,225,761			$ 76,187	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,225,761	$ 1,225,761			$ 76,187	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number METHODIST HOME # 0005439 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

Facility is not subject to real estate taxes

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number METHODIST HOME # 0005439 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 68,281 B. General Construction Type: Exterior BRICK Frame CONCRETE BLOCK Number of Stories 5

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Related business entities are identified on page 6, Schedule VII - Related Parties. Specific facilities located adjacent to The Methodist Home are:

Winwood Apartments, Inc. - 1406 W. Winona - a 31 unit HUD subsidized apartment building for very low income adults.

Glenwood Apartments - 5027 N. Glenwood - a 13 unit apartment complex for very low income adults.

Foster Apartments - 1433 W. Foster - 2-flat - intergenerational housing.

Wellness Center Building - 1355 W. Foster - contains offices of United Methodist Homes & Services and UMH&S Foundation as well as rental space for White Crane Wellness Center.

The costs for these entities are segregated and not included as part of the financial information presented on this report for The Methodist Home.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	HEALTH CARE	39,375	1898-1950	$ 25,000	1
2					2
3	TOTALS	39,375		$ 25,000	3

Facility Name & ID Number METHODIST HOME # 0005439 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	42			1922	$ 214,000	$		$	$	$ 214,000	4
5	48			1951	297,000					297,000	5
6				1972	941,207					941,207	6
7	8			1973	541,942					541,942	7
8	33			1974	479,275					479,275	8
	Improvement Type**										
9	ELEVATOR; HEATING AND A/C SYSTEM			1975	898,240	18,047	25	18,047		898,240	9
10	BEAUTY SHOP AND SWIFT OFFICE			1976	1,203	48	20	48		1,176	10
11	NURSING OFFICE AND CONFERENCE ROOM PARTITION			1980	1,300	28	20	28		1,306	11
12	DINING AND BOILER ROOM			1983	215	11	20	11		192	12
13	DOOR ALARMS			1984	1,188	59	20	59		980	13
14	SIDEWALK; PAVEMENT			1985	7,958	398	20	398		6,167	14
15	FENCING			1986	31,965	1,598	20	1,598		23,174	15
16	SIDEWALK			1987	3,680	184	20	184		2,484	16
17	ROOF & LIGHTING			1988	41,556		10			41,556	17
18	PARKING LOT			1989	123,634		10			123,634	18
19	GROUND FLOOR BATHROOMS AND BEAUTY SHOP			1990	81,482	4,368	10	4,368		81,556	19
20	1ST FLOOR COMMON AREAS			1991	155,195	15,202	10	15,202		146,687	20
21	1ST FLOOR ROOM RENOVATIONS 7 2ND FLOOR NURSING STATI			1992	224,277	21,342	10	21,342		187,376	21
22	LIVING ROOM & 2ND FLOOR HALLWAYS			1993	211,680	19,947	10	19,947		155,282	22
23	3RD FLOOR RENOVATIONS & 4TH FLOOR NURSES STATION			1994	239,782	23,163	10	23,163		151,777	23
24	4TH FLOOR RENOVATIONS & ADMINISTRATIVE OFFICES			1995	143,955	14,374	10	14,374		79,053	24
25	REPLACE CHILLER (AIR CONDITIONING SYSTEM)			1996	264,240	15,658	10	15,658		70,458	25
26	3RD FLOOR RENOVATIONS & SEWER LINE			1997	50,445	6,943	10	6,943		9,077	26
27	NURSING STATION - 2ND FL, DOOR ALARM SYSTEM - 4TH FL, CE			1998	70,774	7,056	10	7,056		17,640	27
28	AUTOMATIC DOOR - LOBBY, 4TH FLOOR - TILE & RENOVATION			1999	33,593	2,998	10	2,998		4,497	28
29											29
30											30
31											31
32											32
33	Total additional items - p12b				305,535	20,851		20,851		152,352	33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 5,365,321	$ 172,275		$ 172,275	$	$ 4,628,088	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number METHODIST HOME # 0005439 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11	Carpeting 1988 - 1992				52,134		5			52,134	11
12	Carpeting			1993	14,437		5			14,437	12
13	Carpeting			1994	21,507		5			21,507	13
14	Carpeting			1995	18,800	1,925	5	1,925		18,800	14
15	Carpeting			1996	17,235	3,447	5	3,447		15,507	15
16	Carpeting			1997	5,198	1,040	5	1,040		3,643	16
17	Carpeting			1998	39,439	7,888	5	7,888		19,720	17
18	Carpeting			1999	531	106	5	106		159	18
19											19
20	Main Stairway Upgrade, Plumbing, Remodeling of Resident Rooms - Floo			2000	76,700	3,835	10	3,835		3,835	20
21	Main Elevator Upgrade			2000	38,713	968	20	968		968	21
22	Air Conditioner - Circulation Pump Replacement			2000	787	16	25	16		16	22
23	Carpeting - 4th Floor, Main Stairway, Rooms - 57, 70, 74			2000	12,458	1,246	5	1,246		1,246	23
24	Parking Lot Improvements - Concrete Replacement, Trees, Fence			2000	7,596	380	10	380		380	24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 305,535	$ 20,851		$ 20,851	$	$ 152,352	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number METHODIST HOME # 0005439 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 1,085,237	$ 94,809	$ 94,809	$		$ 498,915	37
38	Current Year Purchases	64,445	3,222	3,222			3,222	38
39	Fully Depreciated Assets	346,266					346,266	39
40								40
41	TOTALS	$ 1,495,948	$ 98,031	$ 98,031	$		$ 848,403	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	PATIENT TRANSPORT	VAN W/ WHEELCHAIR	1992	$ 34,500	$	$	$		$ 34,500	42
43										43
44										44
45										45
46	TOTALS			$ 34,500	$	$	$		$ 34,500	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 6,920,769	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 270,306	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 270,306	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 5,510,991	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	1997 CHRYSLER CONCORDE	$ 24,620	$ 6,155	$ 21,289	52
53	1998 TOYOTA CAMRY	22,071	5,518	13,795	53
54					54
55					55
56					56
57	TOTALS	$ 46,691	$ 11,673	$ 35,084	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 13,301 Description: Copiers - Leased
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number METHODIST HOME # 0005439 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L39, C3	hrs	$	1,437	$ 64,063	$	1,437	$ 64,063	1
2	Licensed Speech and Language Development Therapist	L39, C3	hrs		19	1,175		19	1,175	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L39, C3	hrs		1,435	75,134		1,435	75,134	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				173,652		173,652	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Med Suppl, Lab, Xray	L39, C2, C3				3,843	55,342		59,185	13
14	TOTAL			$	2,891	$ 144,215	$ 228,994	2,891	$ 373,209	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number METHODIST HOME **#** 0005439 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/00 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 117,670	$	1
2	Cash-Patient Deposits	35,127		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (93,000))	423,399		3
4	Supply Inventory (priced at)	19,561		4
5	Short-Term Investments			5
6	Prepaid Insurance	55,380		6
7	Other Prepaid Expenses	8,128		7
8	Accounts Receivable (owners or related parties)	1,259,207		8
9	Other(specify): A/R - Misc Receivables	56,688		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,975,160	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	36,144		11
12	Long-Term Investments			12
13	Land	25,000		13
14	Buildings, at Historical Cost	5,365,321		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,577,139		16
17	Accumulated Depreciation (book methods)	(5,546,075)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Unamortized Financing Costs	31,037		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,488,566	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,463,726	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 128,375	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	35,127		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	315,013		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	6,243		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Unexpended Restricted Gifts	40,153		36
37	Due to Third-Party Payor	56,569		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 581,480	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	1,225,761		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,225,761	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,807,241	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,656,485	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,463,726	$	48

***(See instructions.)**

Facility Name & ID Number METHODIST HOME # 0005439 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,234,829	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,234,829	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	223,678	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe) **Contrib. Released From Temp. Restriction**	(2,022)	15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 221,656	17	
	B. Transfers (Itemize):			
18	**Equity Transfers**	200,000	18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$ 200,000	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,656,485	24	*

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,531,862	1
2	Discounts and Allowances for all Levels	(739,448)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,792,414	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	275,200	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 275,200	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	7,518	14
15	Telephone, Television and Radio	7,925	15
16	Rental of Facility Space		16
17	Sale of Drugs	199,097	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14,359	19
20	Radiology and X-Ray	1,073	20
21	Other Medical Services	150,099	21
22	Laundry	14,541	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 394,612	23
	D. Non-Operating Revenue		
24	Contributions	13,205	24
25	Interest and Other Investment Income***	6,103	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 19,308	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Winwood Apts. Revenue	27,324	28
28a	Other - See Attached Schedule	14,182	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 41,506	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,523,040	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,200,348	31
32	Health Care	2,051,320	32
33	General Administration	1,211,575	33
	B. Capital Expense		
34	Ownership	377,570	34
	C. Ancillary Expense		
35	Special Cost Centers	398,707	35
36	Provider Participation Fee	59,842	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,299,362	40
41	**Income before Income Taxes (line 30 minus line 40)****	223,678	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 223,678	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,892	2,268	$ 64,993	$ 28.66	1
2	Assistant Director of Nursing	1,882	2,152	50,966	23.68	2
3	Registered Nurses	17,086	19,658	367,694	18.70	3
4	Licensed Practical Nurses	20,410	24,173	345,877	14.31	4
5	Nurse Aides & Orderlies	76,411	82,907	710,743	8.57	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,796	4,239	43,633	10.29	8
9	Activity Director	1,960	2,114	30,946	14.64	9
10	Activity Assistants	6,401	6,547	62,236	9.51	10
11	Social Service Workers	4,859	5,252	83,536	15.91	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	4,201	4,669	54,053	11.58	14
15	Cook Helpers/Assistants	19,305	20,700	145,237	7.02	15
16	Dishwashers	6,697	7,230	48,126	6.66	16
17	Maintenance Workers	8,679	6,794	120,213	17.69	17
18	Housekeepers	17,289	18,785	147,558	7.86	18
19	Laundry	4,228	4,534	31,533	6.95	19
20	Administrator	1,780	2,091	81,406	38.93	20
21	Assistant Administrator					21
22	Other Administrative	19,727	22,395	336,435	15.02	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,771	1,958	23,313	11.91	31
32	Other Health Care(specify)					32
33	Other(specify) Ward Clerks	2,051	2,684	29,641	11.04	33
34	TOTAL (lines 1 - 33)	220,425	241,150	$ 2,778,139 *	$ 11.52	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	520	37,799	L9, C3	36
37	Medical Records Consultant	96	4,032	L10, C3	37
38	Nurse Consultant	377	17,475	L10, C3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	11	220	L11, C3	44
45	Social Service Consultant	80	2,294	L12, C3	45
46	Other(specify) Rehab Consulting	221	9,945	L10A, C3	46
47	Medicare Consultant	Monthly	9,482	L10, C3	47
48	Dietary Management Fees	Monthly	99,347	L1, C3	48
49	TOTAL (lines 35 - 48)	1,305	$ 180,594		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Myra Webster	Administrator		$ 81,406
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 81,406

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
Frost, Ruttenberg & Rothblatt	Audit	7,462
FR&R Consulting	Accounting	5,562
KPMG Peat Marwick LLP	Accounting	475
Providence Managment Systems	Data Processing	20,141
React Computer Services	Data Processing	3,195
Paychex Major Markets	Payroll	2,704
Accounting Solutions	Payroll	479
Mangum, Smietanka & Johnson	Legal	1,084
Witwer, Poltrock & Giampietro	Legal	396
Landon & Wickersty	Legal	5,139
Schuyler, Roche & Zwirner	Legal	4,722
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 51,359

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 61,076
Unemployment Compensation Insurance	33,368
FICA Taxes	211,610
Employee Health Insurance	146,318
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Recognition	11,542
TOTAL (agree to Schedule V, line 22, col.8)	$ 463,914

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	5,837
Health Care Worker Background Check	
(Indicate # of checks performed 188)	1,000
Books & Subscriptions	10,643
Membership Fees	74,158
Advertising & Other	21,596
Less: Public Relations Expense	( )
Non-allowable advertising	(8,147)
Yellow page advertising	(13,124)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 91,963

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 0
In-State Travel	4,169
Seminar Expense	14,753
Entertainment Expense	(0)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 18,922

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. Life Services Network of IL - $4,987

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YEARS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 59,622 Line L10, C2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 59,842
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ N/A Has any meal income been offset against related costs? YES Indicate the amount. $ 7,518

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 0%
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: FROST, RUTTENBERG & ROTHBLATT, P.C. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.